Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Emile Coleman, a prisoner at HMP Isis, on 20 November 2020

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

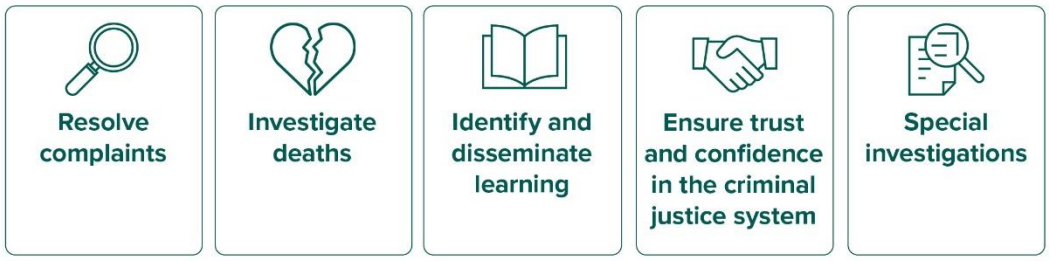
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T l 020 7633 4100

OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Emile Coleman died on 20 November 2020 of a pulmonary embolism (a blood clot in the lung) at HMP Isis. He was 39 years old. I offer my condolences to Mr Coleman's family and friends.

Mr Coleman complained of leg pain four times in the days before he died. We share the clinical reviewer's concern that nurses gave him pain relief without asking him about the pain or examining his leg, contrary to the healthcare provider's standard operating procedure. We have made recommendations about issuing pain relief medication and clinical training.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Sue McAllister CB
Prisons and Probation Ombudsman **January 2022**

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Summary

Events

1. Mr Emile Coleman was remanded into custody in August 2018 for robbery and weapons offences and sent to HMP Thameside. He was sentenced to four years and seven months in February 2019. Mr Coleman transferred to HMP Isis in July 2019.

2. In March 2020, the Prison Service introduced a restricted regime in response to the COVID-19 pandemic. This meant that most activities ceased, and prisoners spent up to 23 hours a day in their cells. Mr Coleman worked as a wing cleaner until October, so spent more time than most prisoners out of his cell. He lost his job in October, so was restricted to his cell much more from that time onwards.

3. On the morning of 17 November, a nurse gave Mr Coleman ibuprofen after he complained of pain in his right leg. Later that afternoon, the same nurse gave him paracetamol when he said he was still in pain. The nurse did not examine his leg or ask him about his leg pain on either occasion. Nurses gave Mr Coleman more ibuprofen on 18 and 19 November for leg pain. Still, no one examined his leg or spoke to him about the pain.

4. At 3.30am on the morning of 20 November, Mr Coleman said he was having trouble breathing. A nurse checked his oxygen levels (which were low), gave him oxygen and arranged for him to be taken to hospital. He went to hospital at 5.15am. When he arrived, a hospital doctor recorded that his right leg was swollen up to the knee.

5. Mr Coleman's breathing continued to deteriorate, and he went into cardiac arrest. His handcuffs were removed to allow hospital staff to treat him. At 8.27am, a prison manager spoke to Mr Coleman's mother to explain her son was in hospital. At 9.09am, a hospital doctor confirmed Mr Coleman's death. Mr Coleman's family were still on their way to the hospital when he died.

6. A post-mortem examination concluded that Mr Coleman died from a pulmonary embolism (a blood clot in the lung), caused by deep vein phlebothrombosis (a blood clot in a vein). He also had severe coronary artery atheroma (narrowed arteries), which did not cause but contributed to his death.

Findings

Clinical Care

7. The clinical reviewer was concerned about the nurses' lack of clinical curiosity when Mr Coleman complained of leg pain. Nurses did not follow the healthcare provider's standard operating procedure before issuing pain relief. They did not examine Mr Coleman's leg or speak to him about the nature or duration of his symptoms.

8. Mr Coleman's weight and relative immobility during the COVID-19 lockdown increased his risk of developing a venous thromboembolism (VTE), a blood clot in his vein. We share the clinical reviewer's concerns about the nurses' apparent lack of awareness of the increased risk of this condition given the restricted regime.

Recommendations

- The Head of Healthcare should ensure that all clinical staff follow appropriate steps when dispensing pain relief without a prescription, in line with the requirements of Oxleas' Homely Remedies standard operating procedure.
- The Head of Healthcare should organise refresher training for all clinical staff around the management of increased risk of venous thromboembolism and pulmonary embolism as a result of the restricted COVID-19 regime.
- The Head of Healthcare should share this report with Nurse A and Nurse B and discuss the Ombudsman's findings with them.

The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Isis informing them of the investigation and asking anyone with relevant information to contact her. She obtained copies of relevant extracts from Mr Coleman's prison and medical records.

10. The investigator interviewed four members of staff at HMP Isis on 6 April 2021. NHS England commissioned an independent clinical reviewer to review Mr Coleman's clinical care at the prison. The investigator and clinical reviewer jointly interviewed healthcare staff.

11. We informed HM Coroner for Inner South London District of the investigation. He gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

12. We are sorry that this report is very late. Most interviews were completed within four months of Mr Coleman's death. We apologise for the added distress this will have caused to Mr Coleman's family.

13. One of the Ombudsman's family liaison officers contacted Mr Coleman's mother and stepfather, to explain the investigation and to ask if they had any matters they wanted the investigation to consider. We did not receive a response to our letter.

14. We shared our initial report with HM Prison and Probation Service (HMPPS). They found no factual inaccuracies. They provided an action plan which is annexed to this report.

Background Information

HMP Isis

15. HMP Isis is a Category C training prison in South East London holding about 600 young adults and men. Oxleas NHS Foundation Trust provides healthcare services.

HM Inspectorate of Prisons

16. The most recent inspection of HMP Isis was in 2018. Inspectors reported that health services remained reasonably good. New arrivals received a health assessment identifying any immediate or ongoing health needs, with an enhanced secondary health and well-being screening the following day. Most services were delivered from the well-equipped health centre, with medication administration and nurse triage clinics from the house block treatment rooms. A weekly obesity clinic was run on both house blocks.

Independent Monitoring Board

17. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for January - December 2020, the IMB reported that the COVID-19 pandemic had been the greatest risk to safety within the prison in 2020. However, the board said that Oxleas NHS Foundation Trust continued to respond to prisoners' healthcare needs within the structure directed by Public Health England (PHE). The health assessments of new prisoners and GP consultations continued during the pandemic, although for some months these had had to be by telephone.

Previous deaths at HMP Isis

18. Mr Coleman was the second prisoner to die at HMP Isis since 2018. The previous death was self-inflicted. There are no similarities between the findings of this investigation and our previous fatal incident investigation at the prison.

Key Events

19. Mr Emile Coleman was remanded into custody on 25 August 2018 for robbery and weapons offences and sent to HMP Thameside. He was sentenced to four years and seven months in prison on 15 February 2019.

20. Mr Coleman transferred to HMP Isis on 29 July 2019. During an initial health screen, he told a nurse that he suffered with anxiety and depression. He was a smoker and weighed over 20 stone. With a Body Mass Index (BMI) of 42, he was considered morbidly obese. Mr Coleman completed a gym induction and took a job working in the prison kitchen, then later as a wing cleaner.

21. From 23 March 2020, the Prison Service introduced a restricted regime in response to the COVID-19 pandemic. Most activities ceased, movement around prisons was restricted and prisoners spent much more time in their cells (often as much as 23 hours a day). Mr Coleman was allowed out of his cell more than most prisoners in order to carry out his duties as a wing cleaner.

22. On 12 October, Mr Coleman's employment as a wing cleaner was terminated and he was given three days cellular confinement after officers found 'hooch' (illicitly brewed alcohol) and two televisions in his cell. At the end of the three days confinement, Mr Coleman was subject to the same restricted regime as all other prisoners on the wing.

23. On 21 October, Mr Coleman saw a nurse for a pre-discharge health check as he was near the end of his sentence. Mr Coleman reported no specific health concerns.

November 2020

24. On the morning of 17 November, Mr Coleman went to the wing medication hatch and told Nurse A that he had pain in his right leg. Nurse A gave Mr Coleman some ibuprofen. She did not ask him about the pain or examine him. Mr Coleman went back to the medication hatch at 4.30pm that afternoon saying that his leg was painful and Nurse A gave him some paracetamol. Again, she did not examine Mr Coleman's leg or ask him anything about the pain.

25. The next morning, on 18 November, Mr Coleman visited the medication hatch again, complaining of leg pain. Nurse A gave Mr Coleman some more ibuprofen, but she still did not ask him about the leg pain or examine him.

26. At around 3.30pm on 19 November, Mr Coleman went to the medication hatch and spoke to Nurse B about his leg pain. Nurse B gave Mr Coleman ibuprofen but did not examine his leg or ask him about the pain.

27. At 3.30am on the morning of 20 November, Mr Coleman pressed his cell bell. An officer went to Mr Coleman's cell. Mr Coleman said he was having trouble breathing. The officer noted that he was alert and could speak in full sentences. The officer radioed for a nurse to examine Mr Coleman. He then contacted the night orderly officer seeking permission to open Mr Coleman's cell.

28. The night orderly officer got to the wing with a nurse and two other officers and opened the cell door. Mr Coleman was sitting on a chair. He said that he had pain in the right side of his chest, was short of breath and had become dizzy when trying to go to the toilet. Mr Coleman said that he had no other symptoms apart from his leg pain that had started on 15 November, five days earlier, which he described as 'cramping'.

29. The nurse checked Mr Coleman's observations and was concerned that his oxygen saturation level was low at 93%. She gave Mr Coleman oxygen, but did not examine his leg. The nurse then gave Mr Coleman aspirin and GTN spray (used to treat chest pain) and asked for an ambulance at 3.50am. Paramedics arrived at 4.10am and stayed with Mr Coleman until 5.15am when they transferred him to Queen Elizabeth Hospital. Mr Coleman was escorted by two officers and restrained with a single handcuff.

30. Mr Coleman arrived at hospital at around 5.45am. He was examined by a doctor who found that his right leg was swollen up to the knee. Mr Coleman had a chest X-ray and bloods were taken.

31. At around 7.08am, Mr Coleman developed breathing difficulties and went into cardiac arrest. His handcuffs were removed to allow hospital staff to treat him. Hospital staff successfully resuscitated him, and he regained consciousness. However, within minutes his heart stopped for a second time. Hospital staff tried to resuscitate him again but were unsuccessful. A hospital doctor confirmed Mr Coleman's death at 9.09am.

Contact with Mr Coleman's family

32. At 8.05am, after Mr Coleman's condition had deteriorated in hospital, a custodial manager tried to telephone Mr Coleman's mother, but she did not answer. He eventually spoke to her at 8.27am and explained that her son was in hospital. Mr Coleman's mother and stepfather said they would get a taxi to the hospital. At 9.12am, the Governor called Mr Coleman's mother to break the news that her son had died. She was still on her way to the hospital at the time.

33. The Governor and the prison's family liaison officer went to the hospital to meet Mr Coleman's mother and stepfather and offer support. The prison kept in regular contact with Mr Coleman's family and offered to contribute towards funeral costs in line with national policy.

Support for prisoners and staff

34. After Mr Coleman's death, a custodial manager arranged for the care team to meet the escorting officers when they got back to the prison from hospital that morning. The Governor debriefed remaining staff involved in the incident later that afternoon to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

35. The prison posted notices informing other prisoners of Mr Coleman's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Coleman's death.

Post-mortem report

36. The post-mortem examination found that Mr Coleman died from a pulmonary embolism (a blood clot in the lung), caused by deep vein phlebothrombosis (a blood clot in a vein). He also had severe coronary artery atheroma (narrowing of the arteries), which did not cause but contributed to his death.

Findings

Clinical Care

Pain relief

37. The clinical reviewer was satisfied that the nurse responded promptly and ensured that an ambulance was called when Mr Coleman became ill on 20 November. However, we share the clinical reviewer's concerns about the response to Mr Coleman's reported leg pain in the days before he died.

38. Between 17 and 19 November, Mr Coleman reported leg pain four times to two different nurses. Mr Coleman was given ibuprofen and paracetamol without a prescription under Oxleas' Homely Remedies standard operating procedure. The clinical reviewer said that a structured clinical assessment is required before dispensing medication under the policy, including establishing the nature and duration of symptoms. She said that this was not followed by the nurses who saw Mr Coleman.

39. The clinical reviewer was concerned that the nurses' "lack of clinical curiosity" led to errors of judgement. The Head of Healthcare told the investigator that it would have been difficult to assess Mr Coleman at that time because he spoke to the nurses at the medication hatch when they were busy dispensing medication. She said that Mr Coleman should have been asked to come back at a time when nurses could have investigated his concerns further.

40. Neither nurse properly assessed Mr Coleman on any of the four occasions he said he was in pain. Neither nurse followed the triage requirements of the Homely Remedies policy. We make the following recommendation:

    The Head of Healthcare should ensure that all clinical staff follow appropriate steps when dispensing pain relief without a prescription, in line with the requirements of Oxleas' Homely Remedies standard operating procedure.

Management of venous thromboembolism (VTE)

41. Mr Coleman was very overweight. There is no evidence to show that healthcare staff gave him weight management advice when he transferred to Isis. The Head of Healthcare said at interview that this should have been picked up by either the Health & Wellbeing Co-ordinator or the long-term conditions nurse. The clinical reviewer said that Mr Coleman's weight and relative immobility during the COVID-19 lockdown would have increased his risk of developing a venous thromboembolism (VTE), a blood clot in his vein.

42. While we understand the difficulties faced during the COVID-19 lockdown period, we share the clinical reviewer's concern that there was a lack of awareness among nurses of the increased risk of VTE due to prisoners' immobility when the restricted regime was introduced. We make the following recommendations:

The Head of Healthcare should organise refresher training for all clinical staff around the management of increased risk of venous thromboembolism and pulmonary embolism as a result of the restricted COVID-19 regime.

The Head of Healthcare should share this report with Nurse A and Nurse B and discuss the Ombudsman's findings with them.

43. The clinical reviewer said that the risks of VTE and immobility are widely known, and risk assessments are well established in the wider NHS. She, therefore, concluded that the care provided to Mr Coleman at Isis was not equivalent to the care he could have expected to receive in the community.

Inquest

44. The inquest, held on 17 October 2023, concluded that Mr Coleman died from natural causes.

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